1. **Can one service provider render CFC PAS/HAB services to two individuals at the same time?**

A service provider may provide CFC PAS/HAB to multiple individuals at the same time. However, the service time for each individual must be calculated using the following formula: (***Number of service providers x length of service event) divided by (the number of persons served) = billable service time per individual.***

Example: If one service provider provided one continuous hour (60 minutes) of CFC PAS/HAB to two individuals, the program provider would bill 30 minutes for each individual. That equates to 2 units of CFC PAS/HAB.

{**1** (service provider) x **60** (length of service)}/ **2** (persons served)

60/2=30

30 minutes=2 units

For more information on units of service and the calculation of units, refer to Section 3830, Calculating Units of Service for Service Claim of the CFC Billing Guidelines found here.

2. **Please explain the sample size for a desk review. Is it based on census per provider or per contract? What determines if a B&P review is conducted as a desk review or an onsite review?**

Appendix I of the HCS and TxHmL Billing Guidelines lays out the processes for determining the sample size of a review. Contributing factors are:

- If this is the program provider's first Billing and Payment review
- Error rate on last Billing and Payment review
- Census per contract

Billing and Payment reviews require a large amount of documentation to be reviewed. For that reason, desk reviews are usually set for sample sizes of less than 11 individuals. During COVID-19, desk reviews can be conducted for program providers that have a review sample of less than 15 individuals. This is to assist a program provider from having to mail, fax, or secure email documents for more than 15 individuals, which can be challenging.

3. **Can IPC's be revised to add the Day Habilitation service component?**

The service planning team may at any time, including during COVID-19, and due to an individual's changing need:

- discuss adding services to an IPC,
- increase units for a specific service component, and

- decrease units for a specific service component.

4. We have an individual that has a doctor's note stating that it is in their best interest to receive Day Habilitation (DH) in their home due to a PTSD diagnosis. Is the doctor's note acceptable and serves as justification or does the program provider need additional documentation for this to happen?

Section 4320 of the HCS and TxHmL Billing Guidelines state that DH can be provided in the individual's residence only if there is a medical or behavioral justification, or if the individual has attained retirement age and requests to receive the service in their residence.

In your specific example, a licensed professional of behavioral support services must have written the order for the individual to remain in their residence as the reasoning or diagnosis requiring the justification, falls within their scope and license. A medical doctor would not be able to order in-home DH for a condition of PTSD as this is not within their scope of practice.

Once the order has been received by the appropriate licensed physician or professional, the individual's PDP and IP should be updated to reflect that DH will be delivered in the individual's residence.

5. Are you going to discuss the new Administrative Penalties?

Questions regarding Administrative Penalties should be referred to Waiver, Survey and Certification. Please send an email to WaiverSurvey.Certification@hhsc.state.tx.us and they will be able to better assist you with your inquiries.

6. Are program providers able to bill for Day Habilitation (DH) over Zoom?

HHSC has not waived the requirement for delivering DH services face-to-face. The administrative aspect of DH can be billed via telehealth (attending an SPT or IDT meeting); however, the actual service delivery of DH must be done face-to-face which means: in the physical presence of an individual that is awake.

7. Does the service coordinator need to document that Day Habilitation (DH) is being provided in the individual's residence due to COVID-19?

HHSC is accepting any note or documentation in the individual's file that stipulates DH is being provided in the individual's residence due to COVID-19. This should be discussed and agreed upon with the individual, LAR/Guardian and service coordinator (SPT) but only documentation of the determination to provide in-home DH is needed in the file.

8. Who can I call with questions regarding billing for services and forms for Transportation and CFC PAS/HAB services?

For questions regarding HHS forms, please contact the Billing and Payment team or the policy team.

Billing and Payment Hotline: 512-438-5359

Billing and Payment Unit Mailbox: hcs.txhml.bpr@hhsc.state.tx.us

HCS Policy unit mailbox: HCSpolicy@hhsc.state.tx.us

TxHmL Policy unit mailbox: TxHmLpolicy@hhsc.state.tx.us

9. Can the review schedule for Billing and Payment be provided to Program Providers?

The Billing and Payment team provides at least 14 days advance notice to program providers of upcoming onsite or desk reviews. The Billing and Payment review schedule is not provided to program providers beyond this notification. The advance notice is appropriate as a program provider must have a program provider representative available during normal business hours (defined as Mon-Fri 8am-5pm, excluding holidays).

10. The HH/CC service provider and individual went out of town for more than two weeks. They were unable to return due to COVID-19. Is the program provider able to bill for Host Home Companion Care- Foster Care during this time?

Since the individual is with their HH/CC service provider, the delivery of HH/CC continues, and the program provider can bill for the service. If the individual and HH/CC are out of the state of Texas, then there may be an issue with the individual's Medicaid eligibility as it may have lapsed. For questions regarding Medicaid eligibility, please contact the Social Security Office or send an email to HHSC Eligibility Verification & Program Support (EVPS) at enrollmenttransferdischargeinfo@hhsc.state.tx.us.

11. Can a program provider have a desk review and an onsite review in the same year?

A program provider will have one routine review at least once every four years. These tend to get scheduled between 3-4 years. There is no limit to the number of special reviews a program provider may receive that are a result of a complaint or referral.

There may be instances where a scheduled, routine, onsite review or desk review has just concluded, but the Billing and Payment team is contacting the program provider again regarding a separate complaint/referral that needs to be completed.

12. May two service providers provide CFC PAS/HAB? One for the weekdays and the other for the weekends.

There is no prohibition against the number of service providers an individual has assisting them or providing them with CFC PAS/HAB. The program provider is responsible for verifying service provider qualifications with every service provider and bill the service claims under the correct Staff ID in the CARE system. An individual may receive CFC PAS/HAB from Staff "A", Monday through Friday then from Staff "B", Saturday and Sundays.

13. Does the IP need to be updated with the date In-home Day Habilitation was provided?

During COVID-19, the IP does not need to be updated with the exact date that the individual started receiving In-home Day Habilitation. A program provider can update the IP if they choose, or simply note in the individual's file when In-home Day Habilitation began and when it ended.

14. I understand it is recommended dayhab services be provided in the individual's residence; however, there is no restriction to opening the dayhab facilities. If dayhab facilities are open, will dayhab be reimbursed?

Currently, there are no restrictions or prohibitions for an individual to attend a Day Habilitation facility and COVID-19 remains an acceptable justification for an individual to receive In Home DH. Both scenarios are billable. The program provider must not restrict an individual from attending dayhab outside of the individual's residence if there is informed decision made by the service planning team (individual, their LAR or Guardian, and the service coordinator). The program provider would screen the individual daily and monitor their health status for any changes.

15. Can a parent of adult individuals who are twins be the temporary service provider of CFC PAS/HAB and Respite during COVID-19?

If the individuals are minors, then the parent does not qualify as a service provider for any service component.

If the individuals are adults (18 and older) then the parent can provide CFC PAS/HAB if they meet all other service provider qualifications listed in Section 3700, Qualified Service Provider Requirements of the CFC Billing Guidelines.

A parent of an individual cannot be the service provider for Respite as the service component definition states that respite is for relief for an unpaid caregiver who resides in the same residence. The individuals should be able to receive respite services if the service planning team agree; however, the service provider cannot be the primary unpaid caregiver.

4610 General Description of Service Component

Revision 19-1; Effective November 15, 2019

(a) Temporary Provision of Assistance

The respite service component:

1. is the temporary provision of assistance and support necessary for an individual to perform personal care, health maintenance and independent living tasks, participate in community activities, and develop, retain and improve community living skills;
2. provides relief for a caregiver of the individual who:
   a. has the same residence as the individual;
   b. routinely provides assistance and support necessary for an individual to perform personal care, health maintenance and independent living tasks, participate in community activities, and develop, retain and improve community living skills;
   c. is temporarily unavailable to provide such assistance and support; and
   d. is not a service provider of host home/companion care, residential support, or supervised living; and
   e. is not a service provider of CFC PAS/HAB unless:
      i. the service provider of CFC PAS/HAB routinely provides unpaid assistance and support to the individual; and
      ii. is used to provide temporary support to the primary caregiver.

16. If a program provider is the owner of a group home, are they responsible for paying for the necessary minor home modifications, or can this be added to the individual(s) IPC?

Minor Home Modifications (MHM) can be added to an individual's IPC regardless of their residential location. Section 6200 of the HCS and TxHmL Billing Guidelines lists the requirements a program provider must follow in order to be reimbursed for the MHM. If the individual's residence is leased by the program provider, host home/companion care service provider, or the individual's family, then an added step in the requirements would be to get the landlord's or property owner's approval for the MHM needed.

17. What billing code should be use for in-home day habilitation services?

The location code for in-home day habilitation during COVID-19 should be "12".

18. What billing code should be used for telehealth service delivery?

Except for Residential Assistance service components, all other services are billed by the location of the service provider delivering the service. If telehealth was

provided for a service component, then the service provider was not in the individual's residence with them; therefore, code "12" is not appropriate. If a service provider was in their office providing telehealth, but the individual was not with them, then identifying the service code as "49" is not appropriate.

In these cases, the billing code to use is "99" for other location.

19. What activities can be provided via telehealth?

During COVID-19, HHSC is allowing the following services to be provided via telehealth for HCS and TxHmL Programs:

- Audiology Services
- Dietary Services
- Occupational Therapy Services
- Physical Therapy Services
- Behavioral Support Services
- Social Work Services
- Speech and Language Pathology Services
- Cognitive Rehabilitation Therapy
- Nursing
- Supported Employment
- Employment Assistance

Telehealth should only be provided if it is within the scope of the service provider's license, for professional therapists and nursing professionals.

20. An IDT and SPT are needed in order to increase the capacity of a 4-person group home by one? Where is this stated?

Information Letters and Provider letters may not go into details regarding what type of documentation is needed to prove that a waiver was implemented by a program provider. While HHSC is waiving certain principals and rules as a response to COVID-19, all other rules, policies and procedures must be followed. Any change to a residential location, even temporary, must be completed as if there is no pandemic or waivers in place. In all cases of waivers/suspensions, the program provider must document that they are utilizing the waiver in the individual's file. Moving an individual from their residence to another requires informed decision making, along with consent from the LAR or guardian and approval from the Service Coordinator. These people make up the service planning team (SPT). While an approval is necessary from these individuals, an IDT meeting would also be beneficial as the staff of the program provider or service provider of RSS or SL must be aware of the changes to a residential group home and discuss staffing, individual needs, etc.

In this example, because an increased number of individuals in a residence will bring additional work for residential service providers, it would be beneficial to have

an IDT meeting in order to discuss concerns or issues. An IDT is not mandated, but a SPT is.

21. What is the difference between an IDT meeting and a PDP?

An IDT meeting is what occurs prior to changes to a PDP, annual or revision, changes to an IPC, IP, etc. IDT stands for "interdisciplinary team" and is made up of the individual, their advocates, provider representatives and service providers rendering the services. A PDP is the person directed plan and is a document which lays out the history of the individual along with the authorized IPC units for the service plan year.

22. Do you still have to enter a temporary discharge if an individual is gone from residence more than 14 days?

An individual should not be placed on temporary discharge when they are out of their group home on a visit. A program provider is not able to bill for RSS, SL, or HH/CC if the individual is out of their residence for more than 14 consecutive days; however, they are able to provide other service components such as day habilitation, nursing, supported employment, etc. Service delivery according to the individual's plan of care must continue unless they are discharged from the facility.

TAC 9.155(e) states the only scenarios when an individual is discharged from their HCS program:

If an individual is temporarily admitted to one of the following settings, the individual's HCS Program services and CFC services are suspended during that admission:

1. a hospital;
2. an ICF/IID;
3. a nursing facility;
4. a residential child-care operation licensed or subject to being licensed by DFPS;
5. a facility licensed or subject to being licensed by the DSHS;
6. a facility operated by DARS;
7. a residential facility operated by the Texas Juvenile Justice Department, a jail, or a prison; or
8. an assisted living facility licensed or subject to being licensed in accordance with THSC, Chapter 247.

23. Is a new CFC PAS/HAB assessment needed to increase the units on an IPC?

During COVID-19, an increase to CFC units does not require a new CFC PAS/HAB assessment.

24. Can you please confirm that program providers should be paying their host home companion care workers for providing dayhab services?

While HHSC cannot make any decisions or take action regarding an employee's or sub-contractor's pay, the rate of Day Habilitation consist of the direct and indirect amount that is paid to the program provider for delivering this service. If it is discovered that a program provider did not pay a service provider for the services rendered (including additional services, such as DH), then a referral should be made to Texas Workforce Commission (TWC) and to The Office of Inspector General (OIG).

25. Is Facetime or Google Duo considered face to face?

Section 2000 of the HCS and TxHmL Billing Guidelines defines face-to-face as:

Face-to-face - Within the physical presence of another person who is not asleep. If a billable activity specifies face-to-face, then that activity cannot be provided via telehealth.

Facetime and Google Duo are allowed telehealth methods as they are secure. Facebook and Snapchat are examples of non-approved platforms for telehealth as they are not secure.

26. Can respite be provided to an individual that has been away from their group home for more than 14 days?

A program provider may provide respite to an individual only if the individual has a documented residential location of "own/family home" on their IPC. If the residential location for an individual is a 3-person, 4-person, or Host Home, then respite services cannot be authorized or provided.

27. Where in the billing guidelines does it state that a nurse needs two signatures for 2 different service times completed on the same day for the same person?

The question was specific to nursing, but B&P is providing an answer for all service components that have a 15-Minute unit of service.

Section 3820(e), Separate Written Service Log or Written Summary Log for Service Component, Subcomponent or Service Event, states:

A program provider must have a separate written service log or separate written summary log for each service component or subcomponent, as described in Section 3810(b)(1)(D), General Requirements, and for each service event as described in Section 3610(a), 15-Minute Unit of Service.

Section 3610, 15-Minute Unit of Service states:

For service components and subcomponents that have a unit of service of 15 minutes, a service event:

(a) Service Event

1. is a discrete period of continuous time during which billable activity for one service component is performed by one service provider;
2. consists of one or more billable activities; and
3. ends when the service provider stops performing billable activity or performs billable activity for a different service component.

Finally, a program provider is not required to use the HHS service delivery logs (SDLs) and can developed their own SDLs. HHSC only requests that the logs contain the same information that the HHS SDL contains. More detail is encouraged, but not less. The HHS site for service delivery logs contains general instructions for each form. Specifically, for Form 4123, Nurse Service Delivery Log-Billable Activities:

General Instructions

- Form 4123 must be used for only one individual.
- Form 4123 must be used for only one service provider. This service provider must provide billable activities during each service claim.
- Form 4123 may be used for up to two **separate billable service claims**. Each billable service claim must be entered **on a separate section**.
- Additional supporting documentation for the Nursing Service Delivery Log is required for all service activities denoted by an asterisk (i.e., reports, assessments).
- Form 4123, or another form created for a similarly intended purpose, is considered a Medicaid document used for Medicaid purposes. As such, by using this form, you understand it is your responsibility to record accurate information, as this information may be subject to a court of law. Failure to record accurate information and/or deliberate falsification of documentation is strictly prohibited.

28. We serve an individual who is so terrified of travel that he becomes combative in any vehicle. In the past oral medication for sedation was minimally effective but is no longer effective. He is now limited in his medical care to physician's who will provide telemedicine. However, he has broken the family computer and they do not have funds to replace it. He moves too swiftly around the room for the physician to see him, and if directed to sit still he will destroy property, as in the family computer. He needs some type of mobile device that can support telemedicine interaction. It appears that this need cannot be met through Medicaid or his HCS Adaptive Aids. Can you please review this issue and address a possible way that Medicaid and/or HCS Adaptive Aids could meet this need? Especially in this new difficult time where telemedicine is becoming the norm, can this be a reconsideration for the use of tablets?

Adaptive aids (AA) cannot be used to purchase a smart phone or tablet computer. AA further cannot be used for the purchase of a personal computer for an individual to use for telemedicine services. Appendix VII states that a personal computer can be purchased as a communication device for the individual and it is ordered by a licensed professional of speech therapy. In this specific situation, the individual needs to continue attending their telehealth medical appointments and there is no medical need or diagnosis for the individual to have a personal computer as their communication method.

In general, if telehealth method of delivering services is approved and appropriate for the individual (case-by-case) the method of delivery should already be in place or made available to the individual not by using waiver funds. The method of delivery is approved (case-by-case) if the means are currently available outside the waiver.

HHSC leadership are reviewing allowance of smart phones and tablets or laptops as an AA, but again they will only be approved for individuals with a diagnosis requiring these devices to communicate effectively.

29. An individual currently receives *Supported Employment (SE)* services. His "job coach" is now able to support him with this service virtually during COVID-19. I did not see any mention of "virtual" support in the billing guidelines. With COVID-19, can you please verify if this individual would be able to receive such service virtually and have them bill for it?

Billable activities for SE and for EA are listed in the HCS and TxHmL Billing Guidelines. Several activities can be delivered via telephone or video or telehealth methods. If an activity must be done face to face for these specific service components, it would be listed by the activity. "Virtual" will not be listed in the billing guidelines or in HHSC communication as the term more recognized and used by CMS is "telehealth". Audio and video make up tele-health and can be used for a

billable activity that does not specify that the activity must be delivered face-to-face.

30. Is HHSC accepting electronic signature for all participants on the IPC?

IL 20-11

To ensure people do not experience a gap in services due to the temporary suspension of face to face service coordination visits for COVID-19, the Texas Health and Human Services Commission will extend Intellectual Disability/Related Condition assessments and individual plans of care expiring at the end of June 2020. In addition, for an IPC being revised during March, April, May, or June 2020, HHSC is not requiring a service coordinator or program provider to conduct a face-to-face visit or obtain signatures on the IPC before the revision is effective.

IPC Revisions

For an IPC that is revised during March, April, May, or June 2020, HHSC is not requiring a service coordinator or program provider to complete a face-to-face visit or obtain signatures on the revised IPC. Service coordinators and program providers may contact individuals by phone to assess a change in status that requires a service plan revision. The program provider or LIDDA service coordinator, as appropriate depending on the program and service delivery type, must enter additional hours or new service into CARE and document justification for the revision. The program provider or LIDDA service coordinator must obtain signatures on a revised IPC within 90 days after the date of the revision. An IPC revised in accordance with this process is subject to utilization review by HHSC to determine if appropriate justification was documented.

Call the IDD Program Enrollment Support message line at 512-438-2484 for ID/RC assessment questions.

Call the IDD Utilization Review message line at 512-438-5055 for IPC extension or revision.

31. What code should be used for the location on the service delivery logs when a service is not provided in the residence, for instance Host Home/Companion Care (HH/CC).

- Went on a day trip to the beach
- Trip for a week with the HHCC
- For 3 weeks with the FC provider

Entries in CARE will still be for the location listed on the IPC. For example, HH/CC will not allow you to enter location “99” in screen C22. That should still be added as code “12”.

For all the examples listed above, the service delivery log can list the group home address, code "12", or "99" and all will be appropriate. Since the HH/CC service provider is with the individual, the narrative should identify that they are out of the residence and on a day trip, or prolonged vacation.

32. Can an individual under the age of 18 provide in-home day habilitation services?

At this time, service provider qualification listed in 3400 of the HCS and TxHmL Billing Guidelines are still in effect and must be followed. A qualified service provider must be an adult in order to provide DH services or any other service component or sub-component.

HCS and TxHmL Billing Guidelines, Section 3400 Qualified Service Provider
3410 General Requirements

Revision 19-1; Effective November 15, 2019

To be a qualified service provider, a person must:

1. be an adult;
2. be a staff member or contractor of the program provider;
3. be paid by the program provider to provide the particular service component or subcomponent being claimed;
4. not be disqualified by this section to provide the particular service component or subcomponent being claimed;
5. meet the minimum provider qualifications described in Section 4000, Specific Requirements for Service Components Based on Billable Activity, for the particular service component or subcomponent being claimed;
6. not have been convicted of an offense listed under §250.006 of the Texas Health and Safety Code; and
7. not be designated in either the Employee Misconduct Registry or the Nurse Aid Registry maintained by HHSC as having abused, neglected or exploited a person or misappropriated a person's property.

33. Are program providers required to complete the Comprehensive Nursing Assessment in-person? What documentation is required if the RN chooses to complete a CNA through telehealth?

The nursing assessment can occur through telehealth; however, the nurse will decide if telehealth is appropriate. For example, telehealth would not an appropriate method if the individual is not able to communicate their concerns or issues but may be appropriate for an individual that is high functioning with limited medical concerns. The program provider must not force the nursing service provider to complete an assessment via telehealth. Of course, the capabilities of telehealth must be available to the individual. If they do not have access to a phone or laptop/computer, then this method would not be approved.

34. Can individuals stay away (i.e. with family) of their residence longer than 14-days and maintain HCS services? If so, can a bed hold fee be charged after 14-days? Can providers continue to charge room and board?

This concern was brought to HHSC by provider groups very early on into the COVID-19 response. Currently the BGs regarding 14 consecutive days away from the facility still apply. A program provider is not able to bill for HH/CC, Supervised Living (SL), or Residential Assistance (RSS) if the individual is away from their residence past the 14th consecutive day. A program provider can charge for "room" but not "board" as the individual is not contributing to decreasing supplies, groceries, etc. This concern has been elevated to HHSC leadership and outside the agency. Any changes to the guideline it will be communicated via an alert to program providers.

An individual maintains their HCS services as an individual away on a visit or vacation does not imply that they are temporarily discharged. A program provider is still responsible for providing other service components or sub-components during the time the individual is not in their residence. An example of this would be providing Speech Therapy or Supported Employment. These services can be provided, regardless of the residential setting of the individual or their temporary location.

35. What services can be provided through telehealth? CFC PAS/HAB? Day habilitation? Employment assistance?

For the services that were listed, only Employment Assistance would be able to be delivered via telehealth and then again, only billable activities that support telephone or video options. CFC PAS/HAB has some billable activities that can be done non-face to face, such as: housekeeping, meal preparation, securing transportation, and preparing medication administration. All other activities for CFC must be face-to-face. DH currently cannot be provided via telehealth. The options for DH are in-home DH by a family member, or residential assistance service provider.

36. Can program providers bill for assessments completed over the phone if video capability is not available?

This really falls under the scope of the licensed service provider. The licensed professional needs to make the determination if video is not needed for an assessment. Nursing assessments are critical and should be completed face-to-face if the individual and LAR/Guardian have no concerns.

37. Can day habilitation be provided during different times of the day or days of the week while an individual is receiving in-home day habilitation (DH)?

The answer is yes; however, DH should not change from what was delivered prior to COVID-19. DH should not be provided based on service provider convenience or availability. If the service provider or primary caretaker works until 5 p.m. and the only time they can provide DH is from 6 p.m. to 11 p.m., that is not appropriate. If DH cannot be provided to the individual in accordance with their plan, then other day activities can be provided.

Also, DH can only be provided face-to-face which means: within the physical presence of another person who is not asleep. If an individual chooses to sleep, then DH service delivery will cease, and the end time should be noted on the log. DH can continue when the individual wakes up.

38. Who can be a service provider of respite? Can all individuals receive respite?

During COVID, HHSC has approved a service provider of respite can be anyone that lives in the home with the individual, except for the primary caretaker or the individual's spouse. If the individual is a minor, then the parent or spouse of a parent is not qualified. The temporary allowance for qualified service providers allows for a family member to provide the service. A program provider is still responsible for doing a background check and meeting all other service provider qualifications in 3400.

Not all individuals can receive respite services. Only individuals with residential location of own/family home (OH/FH) can receive the service.

39. Does telehealth consist of only telephone use or does video have to be involved?

Telehealth may be by phone, by video, or a combination of both. The method should be decided upon by the service provider, especially when dealing with scope of practice and what is allowed under their license.

40. I have a question as to what location would I bill for nursing if provided by telehealth?

A location of service is where the service provider is located. Since the activity was not face-to-face in the individual's residence or in the service provider's office, code 99 (other) is appropriate.

41. If a client did not attend dayhab before this exception, can we engage the HH/CC provider to do in-home dayhab now?

A service can be added to the individual's IPC if the individual, the SC, and LAR/guardian agree.

42. Is it acceptable for nursing notes to have multiple entries with multiple billing codes for same date of service and same location on same note?

A service delivery log for nursing may contain multiple entries for different service times; however, each entry is a service event and must have a narrative, signature, begin and end time, location, etc. One narrative for several times cannot be used. One nurse signature cannot be used for all the service events.

For example, 9-9:30 a.m. and 11-11:45 are listed as service times. Documentation must have the times of service for each service event, a narrative specific for the service event, location, and signature specific to the service event.